PERSPECTIVES

Entitling the Student Doctor

Defining the Student's Role in Patient Care

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Oscar Thompson, a third-year medical student on a shift in the emergency department, is eager to participate in as many procedures as possible. According to the triage nurse's history, the next patient to be seen is a 58-year-old man who has had fever, headache, and neck stiffness. Anticipating his first lumbar puncture, Oscar approaches the room with enthusiasm. The nurse whispers that the patient is irritated and can't wait to see the doctor. The student pauses, draws back the curtain, and says, "Hello, I'm Dr. Thompson, how can I help you today?"

The question of professional identity and how to introduce oneself to patients is one of the first faced by every medical student. Why do medical students introduce themselves as "doctor" and what problems are presented by his choice?

The facts are not difficult. The privilege of being called "doctor" is bestowed by a university on a candidate who has satisfactorily completed the degree requirements at the time of graduation. To call oneself a "doctor" before this time is a lie. But the knowledge, skills, and attitudes of a professional are learned slowly over a period of several years—and continue long after graduation.

To assess the practice and critique of student self-identification, we performed computerized (MEDLINE and BIOETHICSLINE databases) and manual searches of the literature since 1966. We found fewer than 12 articles that directly addressed or even mentioned the issue of student titles; all are cited in this article. Discussion has focused on the ethical,[1] legal[2] and regulatory[3] implications of student introductions. Except for two writers,[4,5] all advised against students using the title of doctor; however, one 1985 study found that the practice was prevalent.[6] This is consistent with our own recent observation. Faculty physicians are responsible for some of the misrepresentation of students. But often it is the student who makes this decision. This article will propose and examine assumptions that we believe may be made by medical students in making this choice. We will then identify the underlying problem and propose solutions.

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ASSUMPTIONS BEHIND USE OF THE TITLE "DOCTOR"

A student in Oscar's situation faces a conflict of interest. He wants to make the patient's care his top priority but also wants to fulfill his own goals by not losing the opportunity to learn a new procedure. The student believes that the two goals of truthful disclosure and optimal learning are in conflict and may even be incompatible. What assumptions might lead the student to pose as "doctor" (Table 1)?

1. The Student Is Not a "Legitimate" Member of the Professional Team

The student may think there is something wrong with the role of the student. This feeling of illegitimacy may be nurtured when patients occasionally make negative comments about repeated examinations or when other members of the care team suggest that the students are in their way. This perception is suggested by one study that showed physicians' children were much less often seen by students when brought to a university-affiliated emergency department, compared with children of nonphysicians.[7]

The question of legitimacy is related to, but distinct from, the question of competence. Students may demonstrate competence in clinical skills through clerkship evaluations or standardized patient examinations. But this does not automatically make them legitimate members of the health care team either in their own eyes or those of others.

Measurement of actual benefit to patients of student involvement is very difficult. There are little empiric data about the "hazards" to patients of student-performed procedures. However, absence of confirmatory data does not mean that a risk does not exist. Considering students' inexperience and the fact that they are frequently a hazard to themselves,[8] student-performed procedures would be expected to carry a higher risk of complication to patients. Although one study of procedural competency in animals found that previous experience was not a significant predictor of competency for medical students, residents, or faculty,[9] more data are needed before conclusions can be

Table 1. Assumptions Students May Make When Using the Title "Doctor"

The student is not a "legitimate" member of the professional team.
The patient may refuse care if student status is revealed.
The patient's right to know the student's identity is not important.
There are times when not telling the patient the truth is acceptable.
Students perform best when they think of themselves as doctors.
Students' learning is jeopardized when their care is refused.
There are no adverse consequences to calling oneself "doctor."

made about the risks students pose to patients. Although the issue of legitimacy is not the same as the issue of competency, students, patients, and faculty may confuse them, thus encouraging students to dishonestly label themselves as the more competent "doctor."

Students recognize that their involvement causes patients to undergo repeated histories and examinations, and to spend more time in clinic, up to 50% more in one study.[10] They may therefore believe their involvement is detrimental, or at least not beneficial, to patients. However, research suggests the opposite. More than 92% of inpatients in one study felt they had benefited from student involvement because the students spent more time with them, were willing to answer their questions, kept them better informed, and used more understandable terminology.[11] We were unable to find empiric evidence that patients perceive student involvement as detrimental to their care.

2. The Patient May Refuse Care If Student Status Is Revealed

Revealing student status carries the risk of provoking fears or distrust in the patient.[5] However, recent surveys reveal that a great majority of patients are willing to have students involved in their care. Studies of American patients[10,12,13] and British patients[14,15] have consistently demonstrated a high percentage (65.8%–95%) are willing to have students involved in their care, although one found a lower acceptance for emotional or sexual problems.[15] Magrane et al. demonstrated that 74% of obstetrical patients accepted student participation in their care, and 73% of those were motivated by "a drive to contribute to the student's education."[16]

3. The Patient's Right to Know the Student's Identity Is Not Important

Students may ignore this right, which is expected by patients.[12,15] By neglecting to disclose their true identity, students are denying the patient the right to refuse treatment.[17] Such neglect was well documented in one study in which 60% of patients had no knowledge that students were involved in their care.[14] Should patients discover they have not been informed, we suspect they will be more likely to refuse future student involvement.

4. There Are Times When Not Telling the Patient the Truth Is Acceptable

By law, students cannot diagnose, prescribe, or administer treatment except under the supervision of a licensed physician.[1,18] Glickman suggested in 1971 that because students assume the essential functions of a doctor, they should be addressed as such.[4] However, performing a function is not the same as qualifying for a degree. For example, physician assistants perform some physician responsibilities, but they are not referred to as "doctor."[1]

Being less than completely honest with a patient may rarely be acceptable. A 1972 court decision (*Cobbs v Grant*, 104 Cal Rptr 505, 502 P2d 1) accorded physicians a "therapeutic privilege" to withhold information that could be detrimental to the patient. This apparent permission to participate in a "lie of omission" has a great potential for abuse, however, and another 1972 court decision strictly limited this paternalistic attitude (*Canterbury v Spence*, 464 F2d at 789). Even without this limitation, however, the therapeutic privilege would not justify a student lying for reasons of self-interest.

The use of the title "doctor" should not vary depending on the patient's medical sophistication, level of education, fluency in English, or litigiousness. Students who feel justified in calling themselves "doctor" when the patient is not medically sophisticated, should also be willing to do so when the patient is a licensed medical professional.

5. Students Perform Best When They Think of Themselves as Doctors

Students may believe they would interact with the patient in a less professional manner, or would assume less responsibility, if they identified themselves as student, rather than doctor.

The student-patient relationship, like the doctor-patient relationship, is based on trust and is undermined by lying.[1] Thus, to lie as a basis for legitimizing the student-patient interaction is detrimental to the development of the student-patient relationship.

Calling oneself "doctor" could be counterproductive to the learning process in another way as well. A patient who believes the student is really a doctor will have higher expectations, and assume the doctor will ask the right questions, examine the right areas smoothly, order the appropriate tests immediately, and know what is wrong and be able to fix it. But students need the freedom to ask more questions, or to ask the patient to undress again, and

they need permission to not know the diagnosis. Students' learning is optimized when they are acknowledged for who they are and given the freedom to be students.[19]

6. Students' Learning Is Jeopardized When Their Care Is Refused

Students view patients not only as people with needs, but also as learning opportunities. Although the bulk of clinical learning comes from direct interaction with patients, students also learn from observing others care for patients.

Medical education is more than the mastery of clinical skills. It should also include learning to uphold patient preference, even if it means sacrificing a personal agenda. It is important to learn to deal with patients who are objecting to a professional recommendation. A student can gain valuable experience by affording patients their rights.

7. There Are No Adverse Consequences in Choosing to Call Oneself "Doctor"

Most patients will probably never know the difference if a student poses as a physician. Few patients will inquire, even fewer will object, and likely none will sue.[18] However, this practice has potential legal pitfalls for the student and the responsible physician, including potential claims of "fraud and deceit, misrepresentation, invasion of privacy, breech of confidentiality and lack of informed consent."[18] Some states have made it a misdemeanor to use the professional title of "doctor" without being a licensed physician (NY 16 Educ Law, sections 6513 and 6522, McKinney 1981 Suppl), and require health care professionals to clearly communicate their educational status to patients (Mass Bd Reg Med, Rules and Regulations, VI3, 1977).

Ethical repercussions are also possible. It could be argued that such misrepresentation is consistent with the principle of beneficence, as no harm will come to a patient who will never know the truth. Yet can we reasonably argue that we have done no harm by lying? In the infrequent situation in which a patient discovers the falsehood, real harm has been done to that patient and to the concept of professional trustworthiness.

In addition, there may be adverse consequences for the student's moral and ethical reasoning. To quote Horn, "In this formative period, such an act sets the stage for future decisions—all made from an unstable base. Beginning one's career lying to patients is hardly a strong ethical foundation."[1] In principle, this ethical dilemma of the student is no different from future decisions involving conflict of interest between duty to the patient and self-interests. Creating a habit of betraying the fiduciary trust for reasons of self-interest is ethically dangerous.

Choosing to lie to a patient may also be detrimental to other students. When a student performs satisfactorily under the title of "doctor," an opportunity is missed to affirm the validity of the student role. It has been shown that previous positive experiences with trainees (residents) is the most important factor in predicting the acceptance of care from training professionals.[20]

Lack of immediate adverse consequences should not justify illegal and unethical behavior. This way of thinking harkens back to a young child's simplistic understanding of the value of rules as being limited to a way to escape punishment.[21] Adults should aspire to a higher method of moral reasoning.

THE UNDERLYING PROBLEM AND PROPOSED SOLUTIONS

Entitling a medical student is a problem because it is an attempt to assign a name to a developing and changing identity. It is difficult to describe or quantify the expectations and level of clinical competency at the various stages of medical training.

The medical student has several possible titles to choose from such as "medical student," "student physician," "extern," or "doctor." These names can mean almost anything, and therefore mean very little. There is no clear role implied by the names students use at the time of introduction. In addition to this nondesignation by default, it is often left to the discretion of students as to what to call themselves.

It might seem appropriate to call students "medical students" early in their training and "student physicians" after they have gained some beginning skills in history taking and physical examination, perhaps after passing the United States Medical Licensure Examination (USMLE), Step 1. However, even this logical distinction is quite arbitrary as the preclinical-clinical distinction is less clear than in past decades. The title of student physician should connote a standard and recognized level of competency that equips the bearer of that title to provide care in the area of history and examination under supervision. Particularly by the final year, when the student has passed two of the three exams for licensure, it should be presumed that he or she has the skills to warrant the title "student physician."

In an ideal setting, the capabilities and limitations of the student physician would be clear, and he or she could fill a legitimate and recognized function on the health care team as an extension of physician-delivered care. When the student appears at the bedside and identifies himself as a "student physician," the patient could expect a responsible learner who performs what he is trained to do under the direct and constant direction of a licensed doctor. This approach is in accord with moral and legal principles—a solution that fulfills ethical duties to the patient and provides an optimal environment for learning.

This solution should be approached from both a professional and a patient level. At a professional level, an effort should be made to clarify and standardize the meaning of

Table 2. Problems and Proposed Solutions in Defining the Student's Role

Problems
Students' professional identity develops and changes.
Multiple student titles imply no clear roles or responsibilities.
Students receive no instruction or supervision about introduction.
Solutions
Student-centered
Standardized student titles like "medical student" as generic term for students in all 4 years, use "student physician" for students who have passed USMLE Step 1.
Instruct students to properly introduce themselves and to inform patients of their roles.
Instruct residents and attending physicians to supervise and reinforce student introductions.
Make appropriate name tags for students.
Codify students' roles and responsibilities in hospital or clinic policy.
Patient-centered
Provide verbal and written information for patients about student involvement, including ways to identify various professionals.
Ask resident and attending physicians to reinforce legitimacy of students' participation.
Provide patients the opportunity to decline student participation.
Remind patients about student involvement and answer questions prior to procedures.

student titles. The term "medical student" should be a generic term to refer to students during their 4 years of medical school. The term "student physician" should be awarded to third-year students who have passed the USMLE Step 1, and who pass a clinical proficiency assessment.

Students should be specifically instructed on how to introduce themselves, and how to let the patient know what responsibilities they will fulfill. There is a range of information the patient could be given: "I am a student physician," with no further explanation; "I am a student physician working with Dr. Jones. We will be taking care of you along with the rest of the surgery team"; or an explanation of what "taking care of you" entails as far as the student's involvement. A decision about how much detail is appropriate should be made on a case-by-case basis, but with a bias toward more information rather than less. Students should also be instructed to wear name tags within the hospital or clinic, clearly identifying themselves as "medical student" or "student physician."

Attending and resident physicians should also be informed that students should not be referred to as "doctor." This instruction should be reinforced by making it a matter of hospital or clinic policy.

From the patient's perspective, there are several things that can be done. Student involvement could be introduced in both verbal and written form at the time of admission to the hospital or clinic so that patients will clearly understand that this is a teaching setting in which students participate in the care. This should be repeated verbally when the resident or attending physician is talking to the patient, when the student introduces himself or herself, or at the time a student is to be involved in a procedure. Patients could be given the opportunity to decline student participation at each of these steps.

When the patient first interacts with the hospital care team, the attending or resident physician should introduce everyone involved with the patient's care, including the student. This validates the student in the patient's eyes, and reaffirms the validity of the student's role in the health care team. Part of the introduction should be to point out to the patient ways to identify individuals in various roles, such as wording on name tags, or the fact that medical students wear short white coats and housestaff and faculty wear long coats, or other practices specific to that hospital or clinic.

At the time of a procedure, the supervising physician should be the one to explain to the patient that the student will be performing the procedure under direct supervision.[22] If the patient has any questions or expresses anxiety regarding the student's involvement, the question should be answered honestly. The supervising physician should emphasize that the student would not be involved if it posed a significant risk to the patient. If the patient continues to be apprehensive or to object, the student should not do the procedure (Table 2).

CONCLUSION

The transient nature of the student-patient relationship leads to unique ethical problems that deserve specific attention.[23] Personal and professional ethics should be part of the medical school curriculum. It is appropriate to focus on such issues as the use of derogatory language in reference to patients, the use of unnecessary procedures for their educational value, and the manner in which students interact with patients.[24–26] Most student issues are directly related to the fact that the student is only partially trained[25,27]; however, the student's identity itself is rarely addressed as an ethical issue. The way students resolve this issue is pivotal in creating the moral basis and ethical habits that will shape their future moral and ethical decisions as professionals.

Posing as a doctor is a hindrance to becoming a doctor. Premature use of the title "doctor" is not acceptable.

The goals of adequately informing the patient and receiving adequate medical training are not mutually exclusive; quite the contrary, adequately informing and communicating honestly with the patient provide the integral foundation on which clinical training, patient interaction, and ethical awareness are built. The academic institution has the privilege and responsibility of entitling the student doctor, of investing the position of "student doctor" with the meaning it deserves and has earned. Let us entitle the student doctor, so students are not tempted to "doctor" their title.

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